



C.L. "BUTCH" OTTER – Governor RICHARD M. ARMSTRONG – Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0009 PHONE 208-334-6626 FAX 208-364-1888

August 13, 2010

Rex Redden, Administrator Idaho Falls Group Home #1 Bellin P.O. Box 50457 Idaho Falls, ID 83405-0457

RE: Idaho Falls Group Home #1 Bellin, Provider #13G024

Dear Mr. Redden:

This is to advise you of the findings of the Medicaid/Licensure survey of Idaho Falls Group Home #1 Bellin, which was conducted on August 6, 2010.

Enclosed is a Statement of Deficiencies/Plan of Correction Form CMS-2567, listing Medicaid deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. <u>It is important</u> that your Plan of Correction address each deficiency in the following manner:

- 1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for all individuals potentially impacted by the deficient practice.
- 2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
- 3. Identify the date each deficiency has been, or will be, corrected.
- 4. Sign and date the form(s) in the space provided at the bottom of the first page.
- 5. Include dates when corrective action will be completed. 42 CFR 488.28 states ordinarily a provider is expected to take the steps needed to achieve compliance within 60 days of being notified of the deficiencies. Please keep this in mind when preparing your plan of correction. For corrective actions, which require construction, competitive bidding or

Rex Redden, Administrator August 13, 2010 Page 2 of 2

other issues beyond the control of the facility, additional time may be granted.

Sign and date the form(s) in the space provided at the bottom of the first page.

After you have completed your Plan of Correction, return the original to this office by August 25, 2010, and keep a copy for your records.

You have one opportunity to question cited deficiencies through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in the State Informational Letter #2007-02. State Informational Letter #2007-02 can also be found on the Internet at:

http://healthandwelfare.idaho.gov/Providers/ProvidersFacilities/StateFederalPrograms/ICFMR/tabid/431/Default.aspx

This request must be received by August 25, 2010. If a request for informal dispute resolution is received after August 25, 2010, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during our visit. If you have questions, please call this office at (208) 334-6626.

Sincerely,

MICHAEL CASE Health Facility Surveyor Non-Long Term Care NICOLE WISENOR Co-Supervisor Non-Long Term Care

MC/srp Enclosures

PRINTED: 08/12/2010 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CONSTRUCTION	(X3) DATE SI COMPLE	
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		13G024	B. WIN	G	08/0	6/2010
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 1664 SOUTH BELLIN IDAHO FALLS, ID 83405	CODE	
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W 000	INITIAL COMMEN	ITS	W	000		
	annual recertificat	onducted by: W, QMRP, Team Leader				
	Common abbrevia report are:	ations/symbols used in this				
W 225	MAR - Medication QMRP - Qualified Professional	thts Committee inary Treatment Team Plan Administration Record Mental Retardation NDIVIDUAL PROGRAM PLAN	W 2	25 w 225		
•	The comprehensiv	ve functional assessment must able, vocational skills.		All individuals have the pote affected by this practice. The assessment form will be revise a section for work interests, re-	vocational ed to incorporate	
	Based on record redetermined the factor and comprehensive obtained for 4 of 4 who were of working assessments were comprehensive as unable to assist ervocational training development of obtaining their abilities. The	is not met as evidenced by: eview and staff interview, it was cility failed to ensure a relevant we vocational assessment was individuals (Individuals #1 - #4) ing age and for whom such e required. Without a sessment, the facility would be ach individual with their ineeds, through the dijectives designed to optimize e findings include: 8/27/09 ITTP documented a 35 agnosed with profound mental		for improving existing or emerg for employment, or present an employment options. All vocat assessments will then be revieupdated using the new form. 2. The QMRP will update the assessment form to include a interests, recommendations for existing or emerging skills nee employment, or present and fuoptions. The vocational assessive annually at each indiplan meeting and will be revise there are significant changes in vocational functioning level the assessment will be updated the year. 3. Target date for completion	ging skills needed d future stonal swed and vocational section for work r improving defor tune employment sments will be viduals treatment as a sneeded. If in the Individuals cocational coughout the	

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: QVSG11

Facility ID: 13G024

If continuation sheet Page 1 of 13

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W 225	Continued From pa	ge 1	w:	225			j
	Her record included dated 6/8/10, that was system (full assistance) verbal/shadowing, in The assessments in scoring consisted orating of each skill in skills, emerging skill the assessment was Summary of Needs	I a Vocational Assessment, was scored using a rating noce, light touch, minimal gesture, and no help). Including various skills and f marking the appropriate n one of three categories (has ils, and no skills). Attached to is a page titled "Narrative".	VV ,	220			
	related to work inter improving existing of	lid not include information rests, recommendations for or emerging skills needed for sent and future employment					
		30/09 ITTP documented a 24 osed with profound mental ebral paly.					
	dated 6/9/10, that w system (full assistant verbal/shadowing, r The assessments in scoring consisted of rating of each skill if skills, emerging skills	ninimal gesture, and no help). Including various skills and If marking the appropriate In one of three categories (has ls, and no skills). Attached to s a page titled "Narrative					
	related to work inter improving existing of employment, or pre- options.	lid not include information rests, recommendations for or emerging skills needed for sent and future employment					
	3. Individual #2's 4/	30/10 ITTP stated she was a					

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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W 225	profound mental refundividual #2's Voca 6/3/10, was scored assistance, light tour minimal gesture, an including various sk marking the approp of three categories and no skills). Attack Narrative Summary However, the assess information related and future employm 4. Individual #1's 10 32 year old female by profound mental refundividual #2's Voca 6/3/10, was scored assistance, light tour minimal gesture, ar including various sk marking the approp of three categories and no skills). Attack Narrative Summary However, the assess information related and future employment. The QMRP sta	whose diagnoses included cardation and cerebral palsy. ational Assessment, dated using a rating system (full ich, verbal/shadowing, id no help). The assessment ills and scoring consisted of riate rating of each skill in one (has skills, emerging skills, ched to the assessment was a of Needs. Sements did not include to work interests or present ment options. 29/09 ITTP stated she was a whose diagnoses included cardation, autism, scoliosis, cts. ational Assessment, dated using a rating system (full ich, verbal/shadowing, and no help). The assessment ills and scoring consisted of riate rating of each skill in one (has skills, emerging skills, ched to the assessment was a of Needs. sements did not include to work interests or present ment options.		225			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MI A. BUIL		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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W 262	updated. The facility failed to vocational assessm comprehensive info 483.440(f)(3)(i) PRCHANGE The committee shomonitor individual properties behaving the opinion of the client protection and the strictive intervent with the approvation of 1 of 3 individual restrictive intervent with the approvation of 1 of 3 individual restrictive intervent resulted in a lack or rights through prior interventions. The 1. Individual #2's 4/36 year old female profound mental reshe relied on a powable to control, for intervention, staff were drive Individual #2 for the first staff were drive Individual #2 for the f	formation and needed to be ensure Individual #1 - #4's nents contained specific and ormation. OGRAM MONITORING & ould review, approve, and orograms designed to manage vior and other programs that, e committee, involve risks to d rights. s not met as evidenced by: eview and staff interviews, it e facility failed to ensure ions were implemented only f the human rights committee s (Individual #2) whose ions were reviewed. This f protection of an individual's approvals of restrictive findings include: 30/10 ITTP stated she was a whose diagnoses included tardation and cerebral palsy. ver wheelchair, which she was mobility. appropriate Driving, revised dividual #2 drove into an object te to back her chair up and	W 2	163	W 262 1. All individuals have the pote be affected by this practice. He approval will be obtained for the restrictive interventions. 2. Anytime a behavior intervention implemented, the Treatment Team will review the intervention and compare it to the behavior modification policy in order to determine if the intervention is restrictive procedure. The Tream will make the determinate sign an addendum to the treatrolar stating which level it falls to according to the behavior modipolicy. If the intervention is found be restrictive, HRC approval who obtained by the QMRP. All reinterventions will be reviewed to HRC every six months or as not throughout the year. 3. Target date for completion of October 6, 2010.	e use of tion is on a timent under iffication and to ill be strictive by the eeded	

	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		ONSTRUCTION	(X3) DATE (
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W 262	Guidelines, revised a neutral area as "A relocate to a differe be used when the imove to a different after they have eng behavior." The Bel Guidelines stated required written conguardian and appropriate and second and se	5/24/10, defined redirection to Assisting an individual to antiarea of the home. This will individual will not independently location to relax or calm down aged in an undesirable navior Modification Program elocation to a neutral area asent from the individual's	W	262			
₩ 263	2:45 - 4:30, the QM received HRC appr Inappropriate Driving The facility failed to obtained prior to the interventions for Inc. 483.440(f)(3)(ii) PR CHANGE The committee shour are conducted only consent of the client minor) or legal guarantees and the conducted only consent of the client minor) or legal guarantees and the restrictive intervention with the written information parent/guardian for #2) whose restrictive	ensure HRC approval was e use of restrictive dividual #2. OGRAM MONITORING & with the written informed it, parents (if the client is a rdian. s not met as evidenced by: view and staff interviews, it is facility failed to ensure ions were implemented only rmed consent of the 1 of 3 individuals (Individual inclined interventions were reviewed. inclied to ensure interventions were reviewed. inclied to ensure interventions were reviewed.	W 2	263			of Page 5 of 13

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W 263	individual's rights the restrictive intervent. 1. Individual #2's 4/36 year old female profound mental results on a powable to control, for A Plan Sheet for In 1/2010, stated if Informer person, staff we drive Individual #2 The facility's Behave Guidelines, revised a neutral area as "// relocate to a different after they have enguidelines stated in required written congulation and approful Individual #2's reconformed consent for When asked during 2:45 - 4:30, the QN obtained guardian and Inappropriate Driving the profuse of the province of the profuse o	prough prior consent for ions. The findings include: /30/10 ITTP stated she was a whose diagnoses included stardation and cerebral palsy, wer wheelchair, which she was mobility. pappropriate Driving, revised dividual #2 drove into an object re to back her chair up and to her bedroom. //or Modification Program // 5/24/10, defined redirection to Assisting an individual to ent area of the home. This will individual will not independently location to relax or calm down gaged in an undesirable havior Modification Program elocation to a neutral area insent from the individual's eval from the HRC. In did not contain written rom the guardian. If an interview on 8/5/10 from the stated she had not consent for Individual #2's ing program. In ensure guardian consent was e use of restrictive	W	263	1. All individuals have the potential taffected by this practice. Written info consent from the guardian will be obtail restrictive interventions. 2. Anytime a behavior intervention is implemented, the Treatment Team with intervention and compare it to the modification policy in order to determ intervention is a restrictive procedure. Treatment Team will make the deterrand sign an addendum to the treatment stating which level it falls under according to the behavior modification policy. If the intervention is found to be restrictive, consent will be obtained by the QMRI Guardian consent will continue to be annually for all on-going interventions needed when new restrictive interventions needed when new restrictive interventions in the process of the process o	ill review behavior ine if the . The mination ont plan dding to e guardian obtained and as tions are	
W 369	I .	IG ADMINISTRATION	W:	369			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: OVSG11

Facility ID: 13G024

If continuation sheet Page 6 of 13

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W 369	The system for drug that all drugs, include self-administered, as all drugs, include self-administered, as all drugs and observation interview it was detensure medications error for 3 of 5 indiving an observed to take in the potential for infull dose of medication. Individual #1's 7/stated she was a 32 received a multivita Solia (an hormonal drug) 8.6 mg every antihistamine drug) daily, Astelin (an anpuffs in each nostril hormonal drug) 100 (an antidepressant During an observation a.m., staff were not multivitamin, Solia, pills, Staff then too of a jar and placed medication cup with pills and applesauciassistance to help I Individual #1 consumixture. When she medication cup and cup away. The Surmedication cup and cup away.	g administration must assure ding those that are are administered without error. Is not met as evidenced by: on, record review, and staff ermined the facility failed to were administered without riduals (Individuals #1, #5, and e medications. This resulted adividuals not to receive the clons. The findings include: 19/10 Physician's Orders 2 year old female. She min (a supplemental drug), drug), Senokot (a laxative other morning, Nasonex (an 1 puff in each nostril twice thistamine drug) 137 mcg 2 twice daily, Synthroid (an 1 mcg each morning, and Paxil drug) 10 mg each morning. Ion on 8/3/10 from 5:45 - 8:20 ed to crush individual #1's Senokot, Synthroid, and Paxil k a spoonful of applesauce out the applesauce in the 1 the crushed pills, mixed the 1 the crushed pills, mixed the 1 the applesauce and pill of finished, staff took the 1 went to throw the medication	W:	369	1. All individuals have the potential affected by this practice. The Hom Supervisor and the Medical Coordiwill retrain all staff on how to accur assist individuals with self administ medications. 2. The Medical Coordinator will conveekly medication observations to that all individuals are being assist administering their medications appropriately and accurately. The Medical Coordinator will complete a medical observations checklist for during each observation. On-going training on how to accurately assist administering all individuals medical will be completed during monthly simeetings by the Home Supervisor Medical Coordinator. The QMRP wattend weekly nurses meetings and review observation checklists that a completed by the Medical Coordinatensure on-going training is being completed. 3. Target date for completion will b October 6, 2010.	ne inator rately tering nduct ensure ed with a t with ations teff and dill dre are etor to	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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W 369	assisting Individual programs stated shapplesauce and pill it easier to scrape of the container to ensall of her medication remaining applesaus spoon and used hat help Individual #1 capplesauce and pill. When asked during 2:45 - 4:30 p.m., the staff should have provided the crown, and allowed I medications from the 2. Individual #5's 7/stated she was a 2-received Regian (a Prevacid (an antiuk). During an observation and pills. Staff then too of a jar and placed mixed the pills in the over hand assistant the drugs. Individual applesauce and pill staff took the bowl. The Surveyor aske	If the observation, the staff #1 with her medication e should have placed the s in a larger container to make out, and should have checked sure Individual #1 consumed ins. The staff then scraped the ice and pill fragments onto a ind over hand assistance to consume the remaining fragments. If an interview on 8/5/10 from the Medical Coordinator stated laced the applesauce in a lushed medications into the individual #1 to consume her ine bowl. 19/10 Physician's Orders 4 year old female. She in antiemetics drug) 10 mg and iter drug) 30 mg each morning. Item on 8/3/10 from 5:45 - 8:20 in an antiemetics drug in the sink item applesauce, and used hand item to help Individual #5 take all #5 consumed the imixture. When she finished, and went to place it in the sink item 1.5 teaspoons of	W:	369			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
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ĺ	NAME OF PROVIDER OR SUPPLIER IDAHO FALLS GROUP HOME #1 BELLIN			1	REET ADDRESS, CITY, STATE, ZIP CODE 1864 SOUTH BELLIN DAHO FALLS, ID 83405		
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W 369	When asked during assisting Individual programs she state fragments have been it is difficult. The stout as possible and then used hand over Individual #5 consultant and pill fragments. When asked during 2:45 - 4:30 p.m., the staff should have enhad been consume 3. Individual #6's 7/stated she was a 3 received Baclofen (mg three times a day from the morning antacid drug) 30 mg carbonate (a supple times a day, vitaminunits in the morning (an anticonvulsant morning, Benadryl (10 cc) two times a drug) in the morning to cc four times a drug) 1 in the morning During an observation, staff were not #6's Carafate, Benaphenobarbital into rithe MAR for the phoc of phenobarbital Surveyor. The pha	g the observation, the staff #5 with her medication ed staff try to ensure all pill en consumed, but sometimes aff stated, they get as much I rinse out the rest. The staff er hand assistance to help time the remaining applesance of an interview on 8/5/10 from the Medical Coordinator stated insured that all medications diprior to rinsing the bowl. 19/10 Physician's Orders to year old female. She is a skeletal muscle relaxant) 30 ay, lactulose (a laxative drug) g, Prevacid solutabs (an interview of a day, calcium emental drug) 500 mg three in D (a supplemental drug) 400 g, phenobarbital suspension drug) 60 mg (15 cc) in the (an antihistamine drug) 25 mg day, multivitamin (a Suplena g, Carafate (an antiulcer drug) day, Sprintec (an hormonal ing.	W	369			

PRINTED: 08/12/2010 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY COMPLETED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) N A. BU		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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W 369	night. During the observal Individual #6 with he asked about the discoversus 15 cc). The dose of 15 cc an instruction for 11:30 measured out the aphenobarbital. When asked during 2:45 - 4:30 p.m., the staff should have so bottle and the MAR. The facility failed to and #6's medication	tion, the staff assisting er medication programs was screpancy in dosage (i.e. 7.5 the staff stated she did not see not had only seen the 7.5 cc of a.m. The staff then dditional 7.5 cc of an interview on 8/5/10 from the Medical Coordinator stated seen the correct dose on the	W	369			
W 370	The system for drug that unlicensed per administer drugs or This STANDARD is Based on observation interview it was detensure medications licensed personnel for 1 of 5 individuals observed taking memedication being a law. The findings in 1. Individual #3's 7/	g administration must assure sonnel are allowed to ally if State law permits. Is not met as evidenced by: on, record review, and staff ermined the facility failed to a were administered only by in accordance with state law is (Individual #3) who were edications. This resulted in dministered contrary to State include: 19/10 Physician's Orders ear old female diagnosed with	W	370			

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BU		PLE CONSTRUCTION G	(X3) DATE S COMPLE	
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	ROVIDER OR SUPPLIER ALLS GROUP HOME	#1 BELLIN		14	REET ADDRESS, CITY, STATE, ZIP CODE 664 SOUTH BELLIN DAHO FALLS, ID 83405		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR OEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 370	Orders documented tablespoon of fiber day. During an observat p.m., a staff was not laxative in the water oom table. However staff was noted to rand assist Individual hand over hand assist Individual hand over hand assist Individual #3 stated certified. Idaho Administrative 2010, defined Unlice (UAP) as unlicensed perform nursing call and supervision of Idaho Administrative states "after complete training program, using the care settings main independently self assisting was stated a medication been assisting Individual manufactured in the staff assisting was stated a medication been assisting Individual.	tardation. Her Physician's d she was to receive 1 laxative in 8 ounces of water a lion on 8/2/10 from 3:00 - 4:00 oted to prepare the fiber r and place it on the dining ver, during snack, a second mix the fiber laxative into water al #3 to take the mixture using sistance. Itaff who was assisting leshe was not medication decreased Assistive Personnel of personnel employed to reservices under the direction dicensed nurses. Additionally, the Code 23.01.01.490.05 etion of a Board-approved in assist patients who cannot endminister medications." Itag an interview on 8/6/10 from the Medical Coordinator and that they were unaware that with the administration of the ot medication certified. Both in certified staff should have	W	370	1. All individuals have the potential affected by this practice. The Hom Supervisor and the Medical Coord will retrain all staff on who can assindividuals with self administering medications. 2. The Medical Coordinator will convectly medication observations to that all individuals are being assist administering their medications appropriately and accurately and olicensed personnel. The Medical Coordinator will complete a medical observation. On-going training on accurately assist with administering individuals medications will be comduring monthly staff meetings by the Home Supervisor and Medical Coordinator. The QMRP will attend weekly nurses meetings and review observation checklists that are comby the Medical Coordinator to ensurgoing training is being completed. 3. Target date for completion will be October 6, 2010.	e inator ist enduct ensure ed with enly by all each how to g all elected e	
W 382	administered by lice 483.460(I)(2) DRUG	ensed personnel.	w	382			

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICARD SERVICES

	TO TOTT WILL DIGITAL	C WILLYOUTH OLIVAIOLO				ONE NO.	0900-0091
	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUI		PLE CONSTRUCTION	(X3) DATE SU COMPLE	
		13G024	B. WII	NG _		08/0	6/2010
NAME OF F	PROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE 664 SOUTH BELLIN		
IDAHO P	ALLS GROUP HOME	#1 BELLIN		1	DAHO FALLS, ID 83405		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
W 382	Continued From pa	ge 1 1	W	382	W 382		
	RECORDKEEPING The facility must ke locked except wher administration.	ep all drugs and biologicals n being prepared for			All individuals have the potential affected by this practice. The Hom Supervisor and the Medical Coordin will retrain all staff on keeping drug biologicals locked except when bein prepared for administration.	e nator s and	
	Based on observati determined the faci and biologicals wer conditions. This fall individuals (Individuals (In	s not met as evidenced by: ion and staff interview, it was lity failed to ensure all drugs e maintained under locked liure directly impacted 1 of 8 lals #3), and had the potential ividuals (Individuals #1 - #8) ty. This resulted in the in the event individuals sted a drug. The findings 19/10 Physician's Orders lear old female diagnosed with tardation. Her Physician's d she was to receive 1 laxative in 8 ounces of water a seconducted on 8/2/10 from uring that time, staff were imedication cart and place a liber laxative on the dining edication cup was left on the from 3:15 - 3:35 p.m. During ividuals and staff were and out of the area preparing g an interview on 8/6/10 from e Medical Coordinator and all drugs should be locked			2. The Medical Coordinator will co weekly medication observations to that all drugs and biologicals are lo except when being prepared for administration. The Medical Coordinator observation checklist form during each observation checklist form during each observation of the during monthly staff me by the Home Supervisor and Medic Coordinator. The QMRP will attensive weekly nurses meetings and review observation checklists that are conby the Medical Coordinator to ensugoing training is being completed. 3. Target date for completion will 1 October 6, 2010.	ensure cked finator ns ation. ately be cetings cal d w npleted ure on-	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		13G024	B. WII	NG		08/06/2010	
NAME OF PROVIDER OR SUPPLIER				ſ	REET ADDRESS, CITY, STATE, ZIP CODE 664 SOUTH BELLIN		
IDAHO F	ALLS GROUP HOME	#1 BELLIN		ı	DAHO FALLS, ID 83405		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF COR PREFIX (EACH CORRECTIVE ACTION : TAG CROSS-REFERENCED TO THE A DEFICIENCY)		HOULD BE COMPLÉTION	
W 382	Continued From page 12		W	382			
	unless being administered.						
}	The facility failed to ensure all drugs were locked except when being administered.						
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STATE FORM

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Bureau d	of Facility Standards					PORW	AFFROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 08/06/2010	
NAME OF P	ROVIDER OR SUPPLIER		STREET AD	DRESS, CITY,	STATE, ZIP CODE		
			UTH BELLIN ALLS, ID 83405				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
MM194	16.03.11.075.10(a) Approval of Human Rights Committee Has been reviewed and approved by the facility's human rights committee; and This Rule is not met as evidenced by: Refer to W262.			MM194	MM194 Refer to W262		
MM196	Guardian Is conducted only to or guardian, or after representative; and	o Consent of Parent of with the consent of the reside ce of the res	e parent	MM196	MM196 Refer to W263	ė	
MM724	As a basis for individual program planning and program implementation, assessments must be provided at entry and at least annually thereafter by an interdisciplinary team composed of members drawn from or representing such professions, disciplines or services areas as are relevant to each particular case. This Rule is not met as evidenced by: Refer to W225.			MM724	MM724 Refer to W 225		
MM753	All medications in locked area(s) except the resident is recept this Rule is not make the resident of the Refer to W382.	(i) Locked Area the facility must be ke ept during those time eiving the medication. eet as evidenced by:	s when	MM753	MM753 Refer to W 382		
Bureau of Fa		DER/SUPPLIER REPRESEN			Jamin.	8/5	(X6) DATE

PAGE 15/17 * RCVD AT 8/24/2010 4:03:36 PM [Mountain Daylight Time] * SVR:DHWRIGHTFAX/0 * DNIS:1888 * CSID: * DURATION (mm-ss):10-10

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Bureau of Facility Standards									
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED			
13G024			08/06/2010			6/2010			
NAME OF P	ROVIDER OR SUPPLIER				STATE, ZIP CODE				
IDAHO F	ALLS GROUP HOME	#1 BELLIN		JTH BELLIN ALLS, ID 83405					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETE DATE		
MM755	Continued From page 1			MM755					
MM755				MM755	MM755				
	Self-Administrate				Refer to W 370				
		t capable of self-adm er staff supervision, l		1					
	must be documente	ed in the resident's							
		residents cannot be a a licensed nurse is or							
	administer and reco	ord such medications							
	This Rule is not me Refer to W370.	et as evidenced by.							
1/11/750	16.03.11.27.02(f)(v	Modication Error		MM759	MM759				
Wilver	10.03.11.27.02(I)(V	/ Wedication Endi		WINI759	D-f 4- \4/ 000				
	Any medication error must be reported immediately to the resident's attending physician and documented in the resident's record. This Rule is not met as evidenced by: Refer to W369.				Refer to W 369				
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If continuation sheet 2 of 2